DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH
REQUEST FOR SECOND OPINION OF DECISION TO TREAT WITH ELECTROCONVULSIVE THERAPY (ECT)

I, _____ (child/legal guardian), request the decision made on _____ day of _____, 20____ to treat me/my child with Electroconvulsive Therapy (ECT) to be reviewed by the organization's Clinical Director or designee.

I understand that this review is a file review only and I will receive a written decision within 48 hours (excluding Saturdays, Sundays and legal holidays) of my request.

_____ _____
Child Name/Legal Guardian Signature Date/Time

Received by _____ _____
Name Date/Time